		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0029876 (various others-see attached)

Facility Name: Misericordia Home-North

Address: 6300 N. Ridge Ave. (Number) Chicago (City) 60660 (Zip Code)

County: Cook

Telephone Number: (773) 273-3033 **Fax #** (773) 743-5439

IDPA ID Number: 362170153-002 through 362170153-0013

Date of Initial License for Current Owners: various

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
	X Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Carolyn Sheehan **Telephone Number:** (773) 273-3033

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from July 1, 2001 to June 30, 2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Kevin Connelly
(Title) Chief Financial Officer

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Misericordia Home-North # ious others-see at Report Period Beginning: July 1, 2001 Ending: June 30, 2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4	177	Intermediate/DD	177	63,808	4
5		Sheltered Care (SC)			5
6	124	ICF/DD 16 or Less	124	44,446	6
7	301	TOTALS	301	108,254	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	61,382	730		62,112	11
12	SC					12
13	DD 16 OR LESS	39,501	749		40,250	13
14	TOTALS	100,883	1,479		102,362	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.56%

D. How many bed-hold days during this year were paid by Public Aid?
7,371 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Adult Vocational Training, 2 CILA Homes and CLF Apartment Living

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started various

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: 06/30/02 Fiscal Year: 06/30/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Misericordia Home-North #arious others-se Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	421,872	208,778	37,096	667,746		667,746	(173,158)	494,588			1
2	Food Purchase		1,360,529		1,360,529		1,360,529	(361,475)	999,054			2
3	Housekeeping	648,649	254,260	232,677	1,135,586		1,135,586	(689,564)	446,022			3
4	Laundry	72,887	41,567		114,454		114,454	(62,266)	52,188			4
5	Heat and Other Utilities			706,360	706,360		706,360	(372,287)	334,073			5
6	Maintenance	593,697	122,201	1,142,960	1,858,858		1,858,858	(960,180)	898,678			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,737,105	1,987,335	2,119,093	5,843,533		5,843,533	(2,618,931)	3,224,602			8
	B. Health Care and Programs											
9	Medical Director	64,623		18,653	83,276		83,276	(22,684)	60,592			9
10	Nursing and Medical Records	1,385,603	422,891	54,333	1,862,827		1,862,827	(510,782)	1,352,045			10
10a	Therapy	12,856,410	14,630	136,625	13,007,665		13,007,665	(3,644,464)	9,363,201			10a
11	Activities	358,908	25,844	43,354	428,106		428,106	(138,181)	289,925			11
12	Social Services	177,024	385	32,965	210,374		210,374	(58,643)	151,731			12
13	Nurse Aide Training											13
14	Program Transportation		64,372		64,372		64,372	(33,096)	31,276			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	14,842,568	528,122	285,930	15,656,620		15,656,620	(4,407,850)	11,248,770			16
	C. General Administration											
17	Administrative	289,098		30,380	319,478		319,478	(135,799)	183,679			17
18	Directors Fees											18
19	Professional Services			169,319	169,268		169,268	(60,198)	109,070			19
20	Dues, Fees, Subscriptions & Promotions			144,625	144,625		144,625	(65,645)	78,980			20
21	Clerical & General Office Expenses	984,453	111,723	356,419	1,452,595		1,452,595	(616,536)	836,059			21
22	Employee Benefits & Payroll Taxes			4,339,713	4,339,713		4,339,713	(1,587,159)	2,752,554			22
23	Inservice Training & Education			104,374	104,374		104,374	(38,037)	66,337			23
24	Travel and Seminar			24,317	24,317		24,317	(6,820)	17,497			24
25	Other Admin. Staff Transportation		1,624		1,624		1,624	(1,624)	(0)			25
26	Insurance-Prop.Liab.Malpractice			65,382	65,382		65,382	(34,408)	30,974			26
27	Other (specify):*											27
28	**TOTAL General Administration**	1,273,551	113,347	5,234,529	6,621,376		6,621,376	(2,546,226)	4,075,150			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	17,853,224	2,628,804	7,639,552	28,121,529		28,121,529	(9,573,007)	18,548,523			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Misericordia Home-North #0029876 (vari Report Period Beginning: July 1, 2001 Ending: June 30, 2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			2,694,665	2,694,665		2,694,665	(1,423,813)	1,270,852			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			2,694,665	2,694,665		2,694,665	(1,423,813)	1,270,852			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	2,080,166	720,078	18,300	2,818,544		2,818,544	(2,816,084)	2,460			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			1,047,258	1,047,258		1,047,258		1,047,258			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	2,080,166	720,078	1,065,558	3,865,802		3,865,802	(2,816,084)	1,049,718			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	19,933,390	3,348,882	11,399,775	34,681,996		34,681,996	(13,812,904)	20,869,093			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Misericordia Home-North #ious others-see a Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(38,074)	2		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(75,856)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(1,038)	25		17
18	Fines and Penalties	(343)	21		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(169,475)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (284,786)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (284,786)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Misericordia Home-North

ID# 76 (various others-see attached)

Report Period Beginning: **July 1, 2001**

Ending: **June 30, 2002**

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Bank Service Fee	$ (1,186)	20	1
2	Hab-Aide Training reimbursement by DHS	(174,479)	10a	2
3	Off-Site Recreational Facility	(10,925)	11	3
4	Depreciation of Non-Care Auto	(7,693)	30	4
5	Expenses Reimbursed from other Sources:			5
6	Dietary Wages	(109,195)	1	6
7	Dietary Supplies	(53,623)	1	7
8	Dietary Other	(10,340)	1	8
9	Food Supplies	(323,401)	2	9
10	Housekeeping Wages	(437,806)	3	10
11	Housekeeping Supplies	(120,982)	3	11
12	Housekeeping Other	(130,776)	3	12
13	Laundry Wages	(51,600)	4	13
14	Laundry Supplies	(10,666)	4	14
15	Heat and Other Utilities	(372,287)	5	15
16	Maintenance Wages	(266,879)	6	16
17	Maintenance Supplies	(63,511)	6	17
18	Maintenance Other	(629,790)	6	18
19	Medical Director Wages/Other	(22,684)	9	19
20	Nursing/Med Records Wages	(377,441)	10	20
21	Nursing/Med Records Supplies	(118,233)	10	21
22	Nursing/Med Records Other	(15,108)	10	22
23	Therapy Wages	(3,415,843)	10a	23
24	Therapy Supplies	(4,677)	10a	24
25	Therapy Other	(49,466)	10a	25
26	Activities Wages	(108,100)	11	26
27	Activities Supplies	(7,223)	11	27
28	Activities Other	(11,933)	11	28
29	Social Services Wages	(49,346)	12	29
30	**Social Services Supplies**	(107)	12	30
31	Social Services Other	-9189.14	12	31
32	Program Transportation	-33095.59	14	32
33	Administrative Wages	-105418.56	17	33
34	Administrative Other	-30380	17	34
35	Professional Services	-60198.13	19	35
36	Dues, Fees, Subscriptions & Promotions	-62327.55	20	36
37	Clerical Wages	-329427.18	21	37
38	Clerical Supplies	-46232.18	21	38
39	Clerical Other	-71058.82	21	39
40	Employee Benefits & Payroll Taxes	-1587159.02	22	40
41	Inservice Training & Education	-38036.89	23	41
42	Travel & Seminar	-6819.57	24	42
43	Other Admin Staff Transportation	-586.44	25	43
44	Insurance	-34408.12	26	44
45	Depreciation	-1340264	30	45
46	Ancillary Service Centers	-2816084	39	46
47	Non-Care Expenses	-2131.75	20	47
48				48
49	**Total**	(13,528,118)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Misericordia Home-North # rious others-s **Report Period Beginning:** July 1, 2001 **Ending:** June 30, 2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(173,158)	0	0	0	0	0	0	0	0	0	0	(173,158)	1
2	Food Purchase	(361,475)	0	0	0	0	0	0	0	0	0	0	(361,475)	2
3	Housekeeping	(689,564)	0	0	0	0	0	0	0	0	0	0	(689,564)	3
4	Laundry	(62,266)	0	0	0	0	0	0	0	0	0	0	(62,266)	4
5	Heat and Other Utilities	(372,287)	0	0	0	0	0	0	0	0	0	0	(372,287)	5
6	Maintenance	(960,180)	0	0	0	0	0	0	0	0	0	0	(960,180)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(2,618,931)	0	0	0	0	0	0	0	0	0	0	(2,618,931)	8
	B. Health Care and Programs													
9	Medical Director	(22,684)	0	0	0	0	0	0	0	0	0	0	(22,684)	9
10	Nursing and Medical Records	(510,782)	0	0	0	0	0	0	0	0	0	0	(510,782)	10
10a	Therapy	(3,644,464)	0	0	0	0	0	0	0	0	0	0	(3,644,464)	10a
11	Activities	(138,181)	0	0	0	0	0	0	0	0	0	0	(138,181)	11
12	Social Services	(58,643)	0	0	0	0	0	0	0	0	0	0	(58,643)	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	(33,096)	0	0	0	0	0	0	0	0	0	0	(33,096)	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(4,407,850)	0	0	0	0	0	0	0	0	0	0	(4,407,850)	16
	C. General Administration													
17	Administrative	(135,799)	0	0	0	0	0	0	0	0	0	0	(135,799)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(60,198)	0	0	0	0	0	0	0	0	0	0	(60,198)	19
20	Fees, Subscriptions & Promotions	(65,645)	0	0	0	0	0	0	0	0	0	0	(65,645)	20
21	Clerical & General Office Expenses	(616,536)	0	0	0	0	0	0	0	0	0	0	(616,536)	21
22	Employee Benefits & Payroll Taxes	(1,587,159)	0	0	0	0	0	0	0	0	0	0	(1,587,159)	22
23	Inservice Training & Education	(38,037)	0	0	0	0	0	0	0	0	0	0	(38,037)	23
24	Travel and Seminar	(6,820)	0	0	0	0	0	0	0	0	0	0	(6,820)	24
25	Other Admin. Staff Transportation	(1,624)	0	0	0	0	0	0	0	0	0	0	(1,624)	25
26	Insurance-Prop.Liab.Malpractice	(34,408)	0	0	0	0	0	0	0	0	0	0	(34,408)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(2,546,226)	0	0	0	0	0	0	0	0	0	0	(2,546,226)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(9,573,007)	0	0	0	0	0	0	0	0	0	0	(9,573,007)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Misericordia Home-North** **# rious others-s** **Report Period Beginning:** **July 1, 2001** **Ending:** **June 30, 2002**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(1,423,813)	0	0	0	0	0	0	0	0	0	0	(1,423,813)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(1,423,813)	0	0	0	0	0	0	0	0	0	0	(1,423,813)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	(2,816,084)	0	0	0	0	0	0	0	0	0	0	(2,816,084)	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(2,816,084)	0	0	0	0	0	0	0	0	0	0	(2,816,084)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(13,812,904)	0	0	0	0	0	0	0	0	0	0	(13,812,904)	45

Facility Name & ID Number Misericordia Home-North # rious others-s Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See attached schedule "Board of Directors during FY02						
Misericordia Home, an equal opportunity employer and provider of service, is separatly incorporated and						
independantly funded. The Catholic Bishop of Chicago, through provisions in Misericordia's By-Laws,						
and Catholic Charities, by virtue of a majority of Board membership, qualify as related organization because						
each has the ability to influence Misericordia's operating policy.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$	Certain costs, primarily related to insurance and/or construction, may		$	$	1
2	V				be paid to either Catholic Charities or the Archdiocese of Chicago. Such costs are paid to				2
3	V				these organizations on a pass-through basis, as part of our participation in collective purchasing				3
4	V				groups. Our share of costs are ultimately paid to external providers not related to us.				4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Misericordia Home-North # (various others-see a Report Period Beginning: July 1, 2001 Ending: June 30, 2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Sr. Rosemary Connelly	Executive Officer	Oversees Misericor	N/A	N/A	50+	100.00	Salary	$ 41,822	17	1
2		Co-Director of Develc	Grants & Direct M	N/A	N/A	50+	100.00	Salary	0	0	2
3											3
4	Note that Sr. Rosemary Connelly's salary is allocated between Development & Community Relations and Program MG&A (MG&A portion is										4
5	further allocated between Misericordia North & South). Also Margaret Murphy's salary is incurred to Development & Community Relations and is not reported										5
6	as an allowable expense on any Cost report.										6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 41,822		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Misericordia Home-North # rious others-s Report Period Beginning: July 1, 2001 Ending: ne 30, 2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Misericordia Home-North #ious others-see Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Misericordia Home-North # ious others-s Report Period Beginning: July 1, 2001 Ending: June 30, 2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1997	8
	1998	9
	1999	10
	2000	11
	2001	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Misericordia Home-North COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0029876 (various others-see attached)

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	N/A Misericordia is not assessed real estate taxes		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Misericordia Home-North # rious others-s Report Period Beginning: July 1, 2001 Ending: June 30, 2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 460,000 B. General Construction Type: Exterior Brick Frame Solid Masonry Number of Stories 1 to 3

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Day Training Facility - approximately 68,000 square feet with 300+ participants
Shannon Apartments - approximately 79,000 square feet with 50 participants
2 CILAs - approximately 9,000 square feet with 12 residents.
CCI facilities - approximately 38,156 square feet with 53 residents.

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Misericordia Home-North # ·ious others-see Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	See Attached Schedule				24,814,117	1,114,981	5-50 yrs	1,039,126	(75,856)	12,728,552	9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Misericordia Home-North # ious others-see Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 24,814,117	$ 1,114,981		$ 1,039,126	$ (75,856)	$ 12,728,552	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Misericordia Home-North # rious others-see Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 3,325,575	$ 198,234	$ 198,234	$	3-20 yrs	$ 2,446,271	71
72	Current Year Purchases	54,803	3,687	3,687		5-20 yrs	3,301	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 3,380,378	$ 201,922	$ 201,922	$		$ 2,449,572	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	See various schedule			$ 244,632	$ 37,497	$ 37,497	$	3	$ 201,405	76
77										77
78										78
79										79
80	TOTALS			$ 244,632	$ 37,497	$ 37,497	$		$ 201,405	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 28,439,127	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 1,354,401	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 1,278,545	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (75,856)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 15,379,529	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Furn & Equip allocated to other prog	$ 2,908,911	$ 164,484	$ 1,965,246	86
87	Non-Care Auto allocated to other prog	271,796	41,661	221,418	87
88	Repairs & Improv allocated to prog	29,821,118	1,134,121	12,636,039	88
89					89
90					90
91	TOTALS	$ 33,001,824	$ 1,340,267	$ 14,822,703	91

G. Construction-in-Progress

	Description	Cost	
92	Nursing Home/CILA/Chapel	$ 779,553	92
93	Laundry Facility	129,705	93
94	Various other projects	624,978	94
95		$ 1,534,236	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Misericordia Home-North # rious others-see Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? ☐ YES ☐ NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- COMMUNITY COLLEGE ☐
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM ☐
- IN OTHER FACILITY ☐
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Misericordia Home-North # ious others-se Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Misericordia Home-North # ious others-see a Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of June 30, 2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,794,639	$	1
2	Cash-Patient Deposits	267,322		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	10,605,325		3
4	Supply Inventory (priced at)	140,771		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 12,808,057	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable	167,819		11
12	Long-Term Investments			12
13	Land	9,680		13
14	Buildings, at Historical Cost	59,134,361		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	8,769,070		16
17	Accumulated Depreciation (book methods)	(34,472,144)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe CIP	1,534,236		22
23	Other(specify): Pledge Receivable	10,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 35,153,022	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 47,961,079	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 678,874	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	253,822		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	1,769,160		30
31	Accrued Taxes Payable (excluding real estate taxes)	45,946		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Unearned Revenue	163,647		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,911,449	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Gift Annuity	272,833		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 272,833	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,184,282	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 44,776,796	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 47,961,078	$	48

***(See instructions.)**

Facility Name & ID Number Misericordia Home-North # various others-see at Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 38,898,942	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 38,898,942	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(6,553,738)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants	7,760,048	11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Net Loss from Misericordia South**	(1,955,320)	15
16	Other (describe) **Development & Community Relations**	(1,809,067)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (2,558,077)	17
	B. Transfers (Itemize):		
18	**Fixed Asset Additions**	2,969,343	18
19	**Funding of Depreciation**	(2,969,185)	19
20	**Transfers to Endowment/Contingency Fund**	8,435,773	20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ 8,435,931	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 44,776,796	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Misericordia Home-North #ious others-see a Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 24,351,158	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 24,351,158	3
	B. Ancillary Revenue		
4	Day Care	3,777,102	4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 3,777,102	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 28,128,260	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	5,843,481	31
32	Health Care	15,656,621	32
33	General Administration	6,621,428	33
	B. Capital Expense		
34	Ownership	2,694,665	34
	C. Ancillary Expense		
35	Special Cost Centers	2,818,544	35
36	Provider Participation Fee	1,047,258	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 34,681,998	40
41	**Income before Income Taxes (line 30 minus line 40)****	(6,553,738)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (6,553,738)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Misericordia Home-North # ous others-see atta Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing		3,370	$ 73,991	$ 21.96	1
2	Assistant Director of Nursing					2
3	Registered Nurses		44,940	1,048,247	23.33	3
4	Licensed Practical Nurses		13,240	263,364	19.89	4
5	Nurse Aides & Orderlies					5
6	Nurse Aide Trainees					6
7	Licensed Therapist		16,430	443,618	27.00	7
8	Rehab/Therapy Aides		13,548	204,909	15.12	8
9	Activity Director					9
10	Activity Assistants		23,716	358,908	15.13	10
11	Social Service Workers		10,234	177,024	17.30	11
12	Dietician					12
13	Food Service Supervisor		520	20,191	38.83	13
14	Head Cook		2,080	44,943	21.61	14
15	Cook Helpers/Assistants		20,045	275,871	13.76	15
16	Dishwashers		6,788	80,868	11.91	16
17	Maintenance Workers		31,658	593,697	18.75	17
18	Housekeepers		56,732	660,722	11.65	18
19	Laundry		6,308	60,813	9.64	19
20	Administrator		9,040	289,097	31.98	20
21	Assistant Administrator					21
22	Other Administrative		21,603	402,172	18.62	22
23	Office Manager					23
24	Clerical		37,367	558,173	14.94	24
25	Vocational Instruction		122,391	2,080,166	17.00	25
26	Academic Instruction					26
27	Medical Director		660	64,623	97.91	27
28	Qualified MR Prof. (QMRP)		94,592	1,541,957	16.30	28
29	Resident Services Coordinator		96,858	1,609,388	16.62	29
30	Habilitation Aides (DD Homes)		728,344	9,056,055	12.43	30
31	Medical Records		2,033	24,593	12.10	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)		1,362,497	$ 19,933,390 *	$ 14.63	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	1,235	$ 37,096	1	35
36	Medical Director	207	18,653	9	36
37	Medical Records Consultant		48,392	10	37
38	Nurse Consultant				38
39	Pharmacist Consultant		5,941	10	39
40	Physical Therapy Consultant	993	39,720	10a	40
41	Occupational Therapy Consultant	2,060	82,390	10a	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	272	10,880	10a	43
44	Activity Consultant				44
45	Social Service Consultant		32,965	12	45
46	Other(specify) Lab work		3,635	10a	46
47					47
48					48
49	TOTAL (lines 35 - 48)	4,767	$ 279,672		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Misericordia Home-North #ious others-see attached) Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sr. Rosemary Connelly	CEO	N/A	$ 41,822
Mary Pat O'Brien	Administrator	N/A	35,791
Denise Tigges	Administrator	N/A	35,486
Terry Petrisko Manaher	Administrator	N/A	28,926
Betty Flynn	Administrator	N/A	35,442
Sr. Catherine McGee	Administrator	N/A	56,756
Maureen Meter	Administrator	N/A	54,875
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 289,098

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Deloitte & Touche	Audit	$ 34,494
ADP Processing	Payroll Service	76,872
American Express	Computer Svc	3,105
Martin Boyer	Unemployment Svc	443
Burke, Warren, MacKay & Serr	Legal	21,089
Archdiocese of Chicago	Insurance fee	33,264
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 169,268

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 138,401
Unemployment Compensation Insurance	24,489
FICA Taxes	920,433
Employee Health Insurance	881,740
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Tuition Reimbursement & Other	58,960
Pension	728,531
TOTAL (agree to Schedule V, line 22, col.8)	$ 2,752,554

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,700
Advertising: Employee Recruitment	64,464
Health Care Worker Background Check	9,784
(Indicate # of checks performed 287)	
Subscriptions	1,400
Membership Dues	225
Illinois Dept of Revenue/inspection	1,407
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 78,980

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	17,497
Due to the small $ amt of each transaction & the high volume	
individuals, gathering & providing such detail would require	
tremendous amt of time, as a result we have not provided such	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 17,497

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Misericordia Home-North # (various others-see attached) Report Period Beginning: July 1, 2001 Ending: June 30, 2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **no**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **no** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? 3-20 yrs

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **129,089** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **1,047,258**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **yes within 50 miles within Illinois**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients?
d. Have vehicle usage logs been maintained? **yes, program vehicles**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes, with the exception of non-care vehicles**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? yes, under c
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A due to salary is unal**

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Deloitte & Touche** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.